		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155249	A. BUII	LDING	00	COMPI 11/10/2	
		133249	B. WIN			1 1/ 10/2	.011
NAME OF F	PROVIDER OR SUPPLIE	R		l	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE		
KINDREI	KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE				WAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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			F0	000			
	This visit was fo	or the Investigation of					
	Complaint IN00	099184 and IN00099274.					
	•	099184 and IN00099274					
	· · · · · · · · · · · · · · · · · · ·	ederal/State deficiencies					
		egations are cited at F201,					
	F250, F279, F28	35, and F406.					
	Survey dates: N	November 9, 10, 2011					
	Facility number:	- 000153					
	Provider number						
	AIM number: 1						
	7 thvi number. 1	00200710					
	Survey team:						
	Sheryl Roth RN	TC					
	Sue Brooker RD						
	Rick Blain RN						
	(November 10, 2	2011)					
	Census bed type):					
	SNF/NF: 139						
	Total: 139						
	Census payor ty	pe:					
	Medicare: 11						
	Medicaid: 99						
	Other: 29						
	Total: 139						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4R9X11

Facility ID:

000153

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
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NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RANDY CHASE COVE		
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Sample: 3						
F0201 SS=D	remain in the facili discharge the resident's welfare cannot be met in the transfer or disconnot be transfer or disconnot be transfer or disconnot be transfer or disconnot be resident.	scharge is appropriate ent's health has improved resident no longer needs					
	The safety of indiv endangered;	iduals in the facility is					
	The health of indivotherwise be enda	riduals in the facility would ingered;					
	appropriate notice under Medicare or facility. For a resid for Medicaid after facility, the nursing	ailed, after reasonable and , to pay for (or to have paid Medicaid) a stay at the dent who becomes eligible admission to a nursing g facility may charge a yable charges under s to operate.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on record review and interview, the F0201 I. Resident #C no longer 12/10/2011 resides in the nursing facility failed to assess, monitor, and center, therefore, no further document behaviors for 1 of 3 residents corrective action could be reviewed for behaviors, and failed to taken for this resident. ensure the physician or facility documented in the clinical record II. All residents with justification as to why the facility could behaviors have the not meet the needs of the resident in the potential to be affected. facility or that the resident was a danger to therefore, this plan of others. [Resident #C] correction applies to all of those residents. The Findings include; medical records of these residents have been Resident #C's record was reviewed on reviewed to determine if 11/9/11 at 10:00 a.m. The record behaviors have been indicated Resident #C's diagnoses appropriately assessed, included, but were not limited to, monitored, and fractured femur (hip), cerebrovascular documented with any accident (stroke), chronic obstructive identified concerns pulmonary disease, legal blindness, and corrected. schizoid personality. At this time there are no residents whose needs A "Pre-Admission Assessment cannot be met in the facility. Summary," dated 1/24/11, indicated All resident records have Resident #C did not have any behaviors or been reviewed in an effort antipsychotic/antianxiety/antidepressant to ensure all recommended medications and was going to LTC for psychiatric follow-up has short term rehab. been done, and to ensure any residents requiring The "Physician Certification for referral to PASRR for Level Long-Term Care Services," dated 1/25/11, II completion have been indicated Resident #C was being admitted referred accordingly. to the facility after a fractured hip repair. The care plans of all The note further indicated the resident residents currently receiving

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE was unable to care for self independently psychotropic medications have been reviewed to at home, required 24-hour care, assist and ensure the same are supervision due to diagnosis. addressed. The care plans of any Resident Progress Notes," dated 1/26/11 resident who have voiced a at 8:00 p.m., indicated resident had some preference for male versus confusion, was yelling at staff to leave female, or vice versa. him alone and was non-compliant with caregivers have been personal alarm. reviewed to ensure the same is addressed. "Resident Progress Notes," dated, 1/26/11 at 1:00 p.m., indicated Resident #C was III. Nursing center staff easily agitated at staff and yells out and have received in-service slaps at staff during care. education relative to behavior management Admission care plan for inappropriate process, including but not behaviors, dated 1/27/11, indicated limited to behavior resident displays inappropriate behaviors assessment, monitoring, as evident by yelling at staff, refusing and documentation. care, and non-compliant with PA. There Social Service staff, was nothing in the care plan that the Business Office Manager, resident was abusive towards residents. and Admissions Coordinator have been The nursing assistant care record for in-serviced on PASRR February 2011, indicated Resident #C had process and requirements. three behaviors 2/1, 2, 3, 4, 7, 8, 9, 11, including but not limited to and two behaviors on 2/12. There were the need for a Level II no behavior sheets or documentation in referral in the event of a the nurse's notes for 2/1, 2, 3, 4, to behavioral condition indicate what the behaviors were or change. behavior summaries from social services. Social Service staff and The behavior for 2/7 was listed in the Licensed Nursing staff have nursing notes which indicated the resident received in-service removed his personal alarm and hid the education relative to the

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE	TED
155249 B. WING 11/10/20	11
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
6006 BRANDY CHASE COVE	
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815	
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CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
THE REGULATOR ESCRIPTION IN CREATION INC.	DATE
parts to it. The nurse's note for 7/9/11 care plan process, including indicated resident had velled at the staff but not limited to inclusion	
all shift. Again, there were no behavior of psychotropic medication sheets or further details to indicate the use, compliance with	
residents. preferences voiced by residents.	
A manfarmana	
Princer harding assistant care record had	
one behavior on the full (1991). The sint	
indu ochaviors A2 on 3/1, 2, 3, 4, 3, 0, 7, 6,	
and one on the 7th and two on the 10th.	
well as DASPD paperwork	
monthly monitoring by social services	
located in the chart for these behaviors.	
no behaviors were noted in the nursing improvement tool has been	
notes for the month of March. developed to monitor	
compliance with addressing	
"Resident Progress Notes," indicated on of psychotronic medications	
4/13/11, resident displayed behaviors and resident care	
toward CNA per therapy. Resident preferences on care plans.	
agitated and threw water pitcher at CNA. Executive Director, or	
designee, and Social	
Inappropriate behavior care plan, dated Service staff, or designee.	
1/27/11, had an updated behavior 4/14/11 shall be responsible for	
but no new interventions. completion of these PI tools	
daily, on scheduled days of	
April monthly behavior monitoring work, for 30 days. Any	
flowsheet had verbal aggression on 4/19. identified concerns will be	
promptly addressed with	
May nursing assistant care record had 3 responsible individual(s).	
behaviors on the 2nd. May monthly	
behavior monitoring flowsheet had IV. Social Service staff will	
inappropriate gestures on 5/7 and 5/8; review findings weekly and	

INTERPETATION NUMBER 156249 SULLDING DO COMPLETED 11/10/2011	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
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History and Physical from a local hospital, dated 6/10/11, indicated								
hospital, dated 6/10/11, indicated		nospital for psychiatric care.						
hospital, dated 6/10/11, indicated		TT:						
"residentof an extended care facility,			-					
		"residentof a	in extended care facility,					<u> </u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/10/2	ETED	
	PROVIDER OR SUPPLIER	CARE AND REHAB-FORT WAYN	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	combativethis j	reasingly agitated and patient has been an cility resident since he ip in February 2011"					
	6/10/11, indicate transferred to the local hospital due	e form was incomplete					
	6/15/11, indicate schizoidalmake prefers male com himself and cont	om local hospital, dated d resident "remains es it clear though that he apany to femalekeeps to inues to isolate with his y remaining in his					
	6/17/11 from a lo Resident #C had 6/10/11 through transferred back indicated the resi times and was to	ansfer Report," dated ocal hospital, indicated been hospitalized from 6/17/11 and was being to the facility. The report dent was confused at follow up with psych s. No follow up was was not done.					
		ge notes indicated the rning to the facility with bilify 3mg every					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4R9X11

Facility ID:

000153

If continuation sheet

Page 7 of 44

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Α (2	X2) MUL	TIPLE CON	ISTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CURRECTION	155249	A	. BUILD	ING	00		11/10/2	
		100248	В	B. WING				11/10/2	011
NAME OF F	PROVIDER OR SUPPLIER					DDRESS, CITY, STA	-		
KINIDDEI	TDANGITIONAL (CARE AND REHAB-FORT	Γ \Λ/Λ∨ΝΙ ⊏			ANDY CHASE 'AYNE, IN4681!			
			· WATINE			ATNE, IN40013	,		
(X4) ID		TATEMENT OF DEFICIENCIES			ID		LAN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FU LLSC IDENTIFYING INFORMATI			REFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT CIENCY)	ΓE	COMPLETION DATE
1710	REGULTION OR	250 DENTI TRIO IN ORMATI	.011)						DATE
	A "Nursing Asse	essment/Full," dated							
		ed Resident #C was							
	· ·	acility on 6/17/11 and							
		nosis of schizoid disorde	. l						
		t list that the resident wa							
		otic medication abilify.							
		esident as a non-smoker							
	~	was occasionally	,						
		ad no mental retardation							
	or dementia.	iu no memai retaruation							
	or ucincilua.								
	Δ "Doctor's Proc	gress Notes," dated							
	· ·	ed Resident #C was sent							
	· ·	ych unit due to increased							
		agitation with mental	·						
	1	ndicated the resident wa							
		sychotic medication) for	Г						
	schizoid disorder	Ι.							
	The "Medication	n Regimen Review," date	_{-d}						
		ned by the pharmacist,	cu						
		ident returned from the							
	^	order for Abilify							
	(anupsycnotic) for	for schizoid disorder.							
	Juno numino a a a a	istant apra records for							
	_	istant care records for	1						
		riors x 2 on $6/1$ and only							
		3, 4, 5, 6, 7, 8, 9, 10, 11	,						
	20. The June mo								
	monitoring flows								
	aggression on the 19th and 20th; inappropriate gestures on 6/5 and								
	throwing objects	s on 6/2. The July							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event	ID: 4R9	X11	Facility ID	D: 000153	If continuation sh	neet Pag	ge 8 of 44

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		LDING	nstruction 00	(X3) DATE COMPL 11/10/2	ETED	
	PROVIDER OR SUPPLIER	I CARE AND REHAB-FORT WAYN	STREET A	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
0	monthly behavior summary/psychoactive GDR review listed no behaviors for June.		o			<i>S.</i> 112
		ess Notes," dated 7/9/11, at confused and yelling at				
	7/12/11, indicate moved from Roo documented] to 1	y Transfer," dated ad Resident #C was am [room number Room [room number bed management.				
	"Resident Progress Notes," dated 7/18/11 at 9:30 a.m., roommate reported writer turning off the air in their room and what the resident had said to the CNA.					
	at 7:50 a.m., CN	ess Notes," dated 7/24/11 A instructed resident to es and resident stated "Go				
	at 11:30 p.m., res MDR this evenir accidentally hit h	ess Notes," dated 7/25/11 sident became upset in ng because a resident nis foot with her w/c threw silverware on the MDR.				
	behaviors marke behavior monitor	stant care record had no d. The July monthly ring flowsheet listed n on 7/18 and 7/25.				

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			ILDING	NSTRUCTION 00		E SURVEY PLETED /2011
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CO RANDY CHASE COVE	DE	
KINDREI	D TRANSITIONAL	CARE AND REHAB-FORT WAY	NE		VAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	_	ess Notes," 7:30 a.m., CNA for asking him to rty clothes.					
	Behavior," dated physically aggre indicated the res housekeeper wh his belongings fi floor being torn indicated Reside on the arm. Pos understand fully temporarily mov	ause of Disruptive 18/18/11, indicated essive behavior. It ident was upset with the o was temporarily moving rom room to lounge while up/replaced. The report ent #C hit the housekeeper sible trigger "did not that his things were being red, thought things were See nurse's notes for					
	August nursing assistant care records have no behaviors. Monthly behavior monitoring flowsheet for August had one inappropriate gesture on the 30th, and verbal aggression on the 3rd, 6th, 9th, 12th.						
	related to use of	risk for adverse effects psychotropic medication 0/8/11 however abilify ane.					
	dated 9/8/11, did	self care deficit (ADL), I not list the resident did not list that resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155249	B. WIN			11/10/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	D TRANSITIONAL (CARE AND REHAB-FORT WAYN	E		RANDY CHASE COVE WAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		g showers and changing		TAG	,		DATE
	clothes or other l						
	Clothes of other t	Deliaviors.					
	Sentember nursi	ng assistant care record -					
	-	ight shift 9/1. There was					
	no September me	_					
	monitoring flows	-					
	momitoring now						
	A "Resident Pro	gress Notes," dated					
		o.m., indicated there was a					
	_	sitor that her 3 year old					
	-	g on the scale in the					
	_	when Resident #C came in					
		child down and swore at					
	-	e for 5:10 p.m., indicated					
		s notified and a new					
		ed to send the resident to					
		or evaluation and					
	•	ast note was timed 7:15					
	p.m. and indicate	ed a call was received					
	^	t's friend who was					
		esident being sent to the					
		There were no other					
	notes after this e						
	A "Resident Tran	nsfer Form," dated					
	10/3/11, indicate	ed Resident #C was					
	transferred to a l	ocal acute hospital					
	emergency room	. Diagnoses included:					
	schizoid personality, hemiplegia,						
	cerebrovascular accident (stroke), anemia						
	and congestive heart failure. The reason						
	for transfer listed	d increased agitation with					
	the resident push	ning a 3 y/o child down.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155249	B. WIN	IG		11/10/2	011
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					RANDY CHASE COVE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYI	NE	FORTV	VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	ertinent information					
		ident pushed a visitor's 3					
	1 *	ho was on the scale. The					
		child to "get his little					
		ote further indicated the					
	_	oulsive behavior, some					
	problems with to	emper and anger at times.					
	October muraina	assistant care records had					
		arked. October monthly					
		oring flowsheet had one					
		ical aggression and anger					
	with others on 1						
	with others on i	0/3.					
	The most recent	inservice for behaviors,					
		ted the following:					
	"some commo	n behaviorsphysical					
	aggressionverl	oal aggressionexit					
	seekingresistir	ng or refusing					
	careobsessive	behaviorif behaviors are					
	not reported and	logged, it is very difficult					
	to maintain then	nthe social worker must					
	be notified in wi	riting of new					
	behaviorsbeha	viors must be logged on					
	the behavior log	s in the nurses station"					
	The current poli	cy and procedure for					
	"Resident Exhib	iting Challenging					
	Behaviors," date	ed 6/30/06 was provided					
	by the Director	of Nursing on 11/10/11 at					
	12:00 p.m. The policy listed the						
	following: "A resident exhibiting						
	behavior sympto	om is intervened with					
	measures that re	duce and/or eliminate					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/10/2	ETED	
NIAME OF F	DDOWIDED OF GUIDN FEE				DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				RANDY CHASE COVE		
KINDREI	O TRANSITIONAL (CARE AND REHAB-FORT WAYN	E	FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	_	es while protecting the others from harmrecord					
		exhibited, interventions					
	` '	essful, and/or successful					
		ed on behavior monitoring					
		cking deviceupdate the					
	resident's care pl						
	_	nicate resident behavior					
	symptoms to app						
		uate resident condition					
	_	least 72-hours or more					
	frequently as det						
	interdisciplinary	teamdocument					
	sequence of ever	nts of resident's behavior					
	in resident's med	lical recorddetails of the					
	eventstaff mon	itoring, if					
	applicabledocu	ment behaviors and					
	interventions on	behavior monitoring log					
	or similar trackir	ng device"					
	An interview we	s conducted with the					
		Administrator (HFA),					
	1	ing (DON) and Social					
		44 on 11/10/11 at 12:20					
		interview, the HFA and					
	DON indicated t						
		rom the physician that the					
		anger to others or that he					
		tted back to the facility.					
		··· · · · · · · · · · · · · · · · · ·					
	An interview wa	s conducted with the					
		Administrator (HFA) on					
		p.m. During the					
		FA indicated the decision					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to not accept the resident back to the facility was made by the interdisciplinary team. This Federal tag relates to Complaint IN00099184 and IN00099274. 3.1-12(a)(4)(A)3.1-12(a)(4)(C)F0250 The facility must provide medically-related social services to attain or maintain the SS=D highest practicable physical, mental, and psychosocial well-being of each resident. F0250 12/10/2011 Based on record review and interview, the F 250 facility failed to ensure a psychiatric appointment was scheduled and attended; I. Resident #C no longer resides in the nursing implemented new interventions and care center, therefore, no further plans for behaviors and preferences for corrective action could be male caregivers, hoarding and fear of taken for this resident. belongings being stolen; to providing complete documentation of behaviors and II. All residents with analysis of potential triggers; to notify behaviors have the PASRR of a change in condition and new potential to be affected, diagnosis; and to follow-up to the therefore, this plan of acquisition of a POA or guardian as correction applies to all of recommended by psych for 1 of 3 those residents. The residents reviewed for behaviors and medical records of these psychiatric diagnosis. [Resident #C] residents have been reviewed to determine if Findings include: behaviors have been appropriately assessed, Resident #C's record was reviewed on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4R9X11

Facility ID:

000153 If continuation sheet

Page 14 of 44

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 11/9/11 at 10:00 a.m. The record monitored, and documented with any indicated Resident #C's diagnoses identified concerns included, but were not limited to, corrected. All resident fractured femur (hip), cerebrovascular records have been accident (stroke), chronic obstructive reviewed in an effort to pulmonary disease, legal blindness, and ensure all recommended schizoid personality. psychiatric follow-up has been done, and to ensure A "Pre-Admission Assessment any residents requiring Summary," dated 1/24/11, indicated referral to PASRR for Level Resident #C did not have any behaviors or Il completion have been antipsychotic/antianxiety/antidepressant referred accordingly. The medications and was going to LTC for care plans of any resident short term rehab. who have voiced a preference for male versus "Resident Progress Notes," dated 1/26/11 female, or vice versa, at 8:00 p.m., indicated resident had some caregivers have been confusion, was yelling at staff to leave reviewed to ensure the him alone and was non-compliant with same is addressed. The personal alarm. care plans of all residents currently receiving "Resident Progress Notes," dated, 1/26/11 psychotropic medications at 1:00 p.m., indicated Resident #C was have been reviewed to easily agitated at staff and yells out and ensure the same are slaps at staff during care. addressed. Admission care plan for inappropriate III. Nursing center staff behaviors, dated 1/27/11, indicated have received in-service resident displays inappropriate behaviors education relative to as evident by yelling at staff, refusing behavior management care, and non-compliant with PA. The process, including but not approaches listed to redirect the resident limited to behavior when inappropriate behaviors occur, assessment, monitoring, remind resident of acceptable behaviors, and documentation. Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE remove resident or other residents from Social Service staff, Business Office Manager. any uncomfortable situations and mental and Admissions health services as needed. No additional Coordinator have been interventions were added in-serviced on PASRR process and requirements. "Resident Progress Notes," dated 1/30/11 including but not limited to at 9:05 p.m., indicated Resident #C takes the need for a Level II his nicotine patch off himself. No care referral in the event of a plan was noted in the clinical record behavioral condition during review on 11/9/11 at 10:00 a.m. for change. the removing of nicotine patch by Social Service staff and resident. Licensed Nursing staff have received in-service "Resident Progress Notes," dated 2/7/11 at education relative to the 4:15 p.m., resident removes personal care plan process, including alarm and hides pieces. but not limited to inclusion of psychotropic medication "Resident Progress Notes," dated 2/20/11 use, compliance with at 7:05 a.m., new order received for recommended psychiatric discontinuing nicotine patch related to follow-up, and any care resident ripping the patch off as soon as preferences voiced by the nurse puts it on times three. residents. A performance March nursing assistant care record had improvement tool has been one behavior on the 9th (AM). PM shift developed to monitor had behaviors x2 on 3/1, 2, 3, 4, 5, 6, 7, 8, compliance with behavior and one on the 9th and two on the 10th. management process, as well as PASRR paperwork Care Plan Conference Summary, dated and required level II. 3/25/11, indicated friend and resident A performance were in attendance but they did not sign improvement tool has been the attendance record. Summary developed to monitor indicated resident prefers doing his own compliance with addressing thing, decreased safety awareness, poor of psychotropic medications

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155249	A. BUII B. WIN	LDING G		11/10/2	
KINDREI (X4) ID				STREET A 6006 BF FORT W	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	therapy, discharg living. "Resident Progre 4/13/11, resident toward CNA per Resident agitated at CNA. Inappropriate bel 1/27/11, had an ubut no new interval agression and 1 gestures. "Resident Progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progre 6:30 p.m., indical shoving a glass of the sident progree for	chavior monitoring rbal aggression on 4/19. Istant care record had 3 2nd. May monthly ring flowsheet had stures on 5/7 and 5/8; n on 2nd and 8th. The r summary/psychoactive which reviewed May incidents of verbal of inappropriate Sess Notes," dated 6/2/11 at ted resident observed of milk towards a resident use resident was tapping			and resident care preferences on care pla Executive Director, or designee, and Social Service staff, or designer shall be responsible for completion of these PI to daily, on scheduled days work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s) IV. Social Service staff review findings weekly a report to PI committee monthly for 6 months to determine need for continued monitoring thereafter. Completion Date: 12.10.11	ee, cols s of ce n o.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BU	ILDING	NSTRUCTION 00		(3) DATE SUR' COMPLETE 11/10/2011		
	PROVIDER OR SUPPLIER	L CARE AND REHAB-FORT V	B. WI	STREET A	ADDRESS, CITY, STA RANDY CHASE VAYNE, IN4681	COVE		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S I (EACH CORRECTIV CROSS-REFERENC	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	co	(X5) MPLETION DATE
	7:30 p.m., reside a peer and purpo A new care plan another resident	ess Notes," dated 6/2/11 at ent witnessed walking past sefully kicking peer. listed resident kicking 6/6/11. The new eated to notify the						
	Physician or Pov (resident did not find source of co	ver of Attorney POA have a POA), attempt to onflict, separate residents and remove resident						
	6/8/11, indicated	nitoring Tool," dated I the resident threw a and that the resident was e checks.						
	4:25 p.m., spoke going to Generat go but Generatio	ess Notes," dated 6/8/11 at with resident regarding tions. Resident agreed to ons stated he does not for inpatient admission.						
	hospital, dated 6. "residentof a who recently bed and combative extended care fact had a fractured h "Resident Progre	sical from a local /10/11, indicated n extended care facility, came increasingly agitated this patient has been an cility resident since he aip in February 2011"						
FORM CMS-2	567(02-99) Previous Version		4R9X1 ²	Facility 1	D: 000153	If continuation she	et Page 1	 8 of 44

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	r í	SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BUI	LDING	00		LETED
		155249	B. WIN			11/10/	2011
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYI	NE		RANDY CHASE COVE VAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DETCIENCT)		DATE
		rations and faxed					
	paperwork and the 4:00 p.m. note indicated resident transferred to Generations.						
	Generations.						
	A "Resident Tra	nsfer Form," dated					
		ed Resident #C was being					
	*	e psychiatric unit at a					
	local hospital du						
	disturbance.						
	Progress notes f	rom local hospital, dated					
	6/15/11, indicate	ed resident "remains					
	schizoidalmak	es it clear though that he					
	prefers male cor	npany to femalekeeps to					
	himself and con	tinues to isolate with his					
	headphones or b	y remaining in his					
	room"						
		ansfer Report," dated					
		ocal hospital, indicated					
		l been hospitalized from					
		6/17/11 and was being					
		to the facility. The report					
		sident was confused at					
		o follow up with psych					
		ks. No follow up was done					
	_	e of condition reported to					
		Screening and Resident					
	· ·	R) services to have a level					
	-	nich is completed to ensure					
		serious mental illness					
		resident in a nursing					
	tacility, and spec	cifies services required in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/10/2	ETED	
	PROVIDER OR SUPPLIER			6006 BF	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
KINDREI		CARE AND REHAB-FORT WAYN	1E	FORTV	VAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	order for the place	cement to be appropriate.					
	A "Nursing Asse 6/17/11, indicate admitted to the findicated a diagr. The form did not on the antipsych again listed their that the resident confused, and had or dementia. A "Doctor's Prog 6/20/11, indicated out to a local psy increased combarmental health his resident was on medication) for surface of the first and the second of the s	essment/Full," dated ed Resident #C was facility on 6/17/11 and mosis of schizoid disorder. It list that the resident was otic medication abilify. It resident as a non-smoker, was occasionally and no mental retardation egress Notes," dated ed Resident #C was sent exchiatric unit due to ativeness, agitation with story. Indicated the Ability (antipsychotic schizoid disorder. iistant care records for miors x 2 on 6/1 and only 1 and 3, 4, 5, 6, 7, 8, 9, 10, 11, bonthly behavior sheet had verbal					
	GDR review list	ed no behaviors for June.					
	_	ess Notes," dated 7/9/11, at confused and yelling at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/10/2	ETED	
		133249	B. WIN		DDDDGG GUTY GTATE TID GODE	11/10/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (CARE AND REHAB-FORT WAYN	IE		VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	staff all shift.	ESC IDENTIFICATION)	+	1710			BITTE
	Starr arr Sinre.						
	"Resident Progre	ess Notes," dated 7/11/11					
	•	ter spoke with friend					
		or guardianship being					
		ident friend is an attorney					
		write up paperwork and					
	_	oon. There was no					
	•	tation of a follow up to					
	the POA request.	•					
	•						
	An "Intra-facility	Transfer," dated					
	7/12/11, indicate	d Resident #C was					
	moved from Roo	om [room number					
	documented] to	Room [room number					
	documented] for	bed management. There					
	was no care plan	for adjustment to the					
	facility or to the	room change.					
		35					
	_	ess Notes," dated 7/18/11					
		mmate reported writer					
	_	r in their room and what					
	the resident had s	said to the CNA.					
	"Dagidant Drass	ess Notes," dated 7/24/11					
	•	A instructed resident to					
		es and resident stated "Go					
	f yourself."	o and restuent stated. Ou					
	1 yoursen.						
	Resident Progres	s Notes," dated 7/25/11					
	_	sident became upset in					
	MDR this evening because a resident						
accidentally hit his food with her w/c							
		threw silverware on the					
	*						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155249	B. WIN	G		11/10/2	011
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	O TO ANOITIONIAL		_		RANDY CHASE COVE		
KINDREI) TRANSITIONAL (CARE AND REHAB-FORT WAYN	E	FORTV	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ground and left I	VIDR.					
	T 1						
		stant care record had no					
		d. The July monthly					
		ring flowsheet listed					
	verbai aggressio	n on 7/18 and 7/25.					
	"Resident Progre	ess Notes," 7:30 a.m.,					
	_	CNA for asking him to					
	change out of di	•					
	our or un	• • • • • • • • • • • • • • • • • • • •					
	"Determining Ca	ause of Disruptive					
	Behavior," dated	1 8/18/11, indicated					
	physically aggre	ssive behavior. It					
		ident was upset with the					
		o was temporarily moving					
	_	rom room to lounge while					
	"	up/replaced. The report					
		ent #C hit the housekeeper					
		sible trigger "did not					
		that his things were being					
	I -	red, thought things were					
		See nurse's notes for					
		here was no care plan for					
		arding or concerns with					
	his belongings b	•					
	August nursing a	assistant care records have					
	no behaviors. M	Ionthly behavior					
	monitoring flow	sheet for August had one					
		sture on the 30th, and					
		n on the 3rd, 6th, 9th,					
	12th.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BUI	LDING	00	COMPL		
		155249	B. WIN			11/10/2	011
NAME OF I	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIED	N.		6006 BF	RANDY CHASE COVE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYN	ΙE	FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	macist's medication					
		dated 8/28/-8/30/11,					
		ere missing in the chart.					
		note indicated the resident					
	had refused and	the orders were canceled.					
	A care plan for r	risk for adverse effects					
	related to use of	psychotropic medication					
	(abilify), was da	ted 9/8/11 even though					
	the resident start	ted the medication in					
	June.						
	A care plan for s	self care deficit (ADL),					
	dated 9/8/11, did	d not list that the resident					
		and it did not list that the					
	•	n refusing showers and					
		s or other behaviors.					
		s of other behaviors.					
	September nursi	ng assistant care record -					
	-	night shift 9/1. There was					
	no September m	_					
	monitoring flow	_					
	monitoring now	D1100t.					
	"Resident Progra	ess Notes," dated 10/3/11					
	1	eident when resident					
	_						
		oy. Doctor notified at					
	•	rder received to send					
	resident to St. Jo	pe for eval and treat.					
	A UD 1 . 4 TO	C F !! 1.4. 1					
		nsfer Form," dated					
	· ·	ed Resident #C was					
		local acute hospital					
		n. Diagnoses included:					
	schizoid persona	ality, hemiplegia,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			LDING	NSTRUCTION 00		X3) DATE S COMPLI 11/10/20	ETED	
NAME OF F	DROWIDED OF GUIDNI 101				DDRESS, CITY, STAT	E, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K			RANDY CHASE C	OVE		
KINDREI	D TRANSITIONAL	CARE AND REHAB-FORT WAY	YNE	FORT W	/AYNE, IN46815			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED DEFICI	TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICI	ENCY)		DATE
		accident (stroke), anemia						
		neart failure. The reason						
		d increased agitation with						
	-	ning a 3 y/o child down.						
	_	ertinent information sident pushed a visitor's 3						
		ho was on the scale. The						
	l =	child to "get his little						
		ote further indicated the						
		oulsive behavior, some						
	_	emper and anger at times.						
	problems with to	imper und unger at times.						
	October nursing	assistant care records had						
	_	arked. October monthly						
		oring flowsheet had one						
		ical aggression and anger						
	with others on 1							
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	Interdisciplinary	Discharge Summary,						
		ndicated: discharged to						
	generations, able	e to make needs known,						
	alert and oriente	d x 3, ambulatory, needs						
		s, abusive behaviors - sent						
	to Generations for	or eval/treat, resident						
	preferred to be a	lone listening to his						
		tching tv. Form was						
		reas: personal belongings						
	sentvitalslab	setc. Discharge						
	summary was no	ot necessary since resident						
	went out on an e	emergency basis.						
		inservice for behaviors,						
	-	ted the following:						
	"some commo	n behaviorsphysical						
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	4R9X11	Facility II	D: 000153	If continuation sh	eet Pac	ne 24 of 44

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155249	B. WIN			11/10/2	011
NAME OF B	DOMDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIEF			6006 BF	RANDY CHASE COVE		
KINDRED		CARE AND REHAB-FORT WAYN	IE	FORT V	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRI			
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		oal aggressionexit					
	seekingresistin	-					
		behaviorif behaviors are					
	-	logged, it is very difficult					
		the social worker must					
	be notified in wr	•					
		viors must be logged on					
	the behavior log	s in the nurses station"					
	Th	1 1 C					
	-	cy and procedure for					
		iting Challenging					
	,	ed 6/30/06 was provided					
	-	of Nursing on 11/10/11 at					
	12:00 p.m. The	• •					
	-	resident exhibiting					
	• •	om is intervened with					
		duce and/or eliminate					
	-	es while protecting the					
		others from harmrecord					
		exhibited, interventions					
		essful, and/or successful					
		ed on behavior monitoring					
		cking deviceupdate the					
	resident's care pl						
		nicate resident behavior					
	symptoms to app	_					
	-	luate resident condition					
	•	t least 72-hours or more					
	frequently as determined by the						
	interdisciplinary teamdocument						
		nts of resident's behavior					
	in resident's med	lical recorddetails of the					
	eventstaff mon	nitoring, if					
	applicabledocu	ument behaviors and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	C	DATE SURVEY COMPLETED /10/2011	
	PROVIDER OR SUPPLIER	CARE AND REHAB-FORT WAYNI	600	EET ADDRESS, CITY, STA 16 BRANDY CHASE RT WAYNE, IN4681	COVE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
	interventions on or similar tracking	behavior monitoring log ng device"				
	Services #2 on 1 During the intervindicated there we psychiatric visit from a local psychiatric visit from a local psychiatric visit from a local psychiatric psychiatric visit from a local psychiatric psychiatric visit from a local psychiatric psychiatric visit June for Resident indicated there we preference for me indicated he initial before he changed care planned.	s conducted with Social 1/10/11 at 12:20 p.m. view, Social Service #2 vas no follow up to a requested upon discharge chiatric facility back in t #C. She further vas no care plan for ale caregivers, she ally had a male caregiver ad rooms but it wasn't relates to Complaint 1N00099274.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/10/2011
		CARE AND REHAB-FORT WAYNE	STREET . 6006 B	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE WAYNE, IN46815	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
F0279 SS=D	The facility must decare plan for each measurable object a resident's medic psychosocial needs comprehensive as. The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights oright to refuse treat Based on record facility failed to resident's prefere behaviors of refuse and take showers interventions for residents reviewed plans. [Resident #C's received the plans of the plans o	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes lives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). review and interview, the update the care plan for nice for male caregivers, sing to change clothes and provide additional behaviors for 1 of 3 and provide additional behaviors for 1 of 3 and provide additional behaviors and care #C]	F0279	F 279 I. Resident #C no longer resides in the nursing center, therefore, no furth corrective action could be taken for this resident. II. All residents with behaviors have the potential to be affected, therefore, this plan of correction applies to all those residents. The medical records of these residents have been reviewed to determine if behaviors have been	of e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE pulmonary disease, legal blindness, and appropriately assessed, monitored, and schizoid personality. documented with any identified concerns A "Nursing Assessment/Full," dated corrected. All resident 1/25/11, indicated Resident #C was records have been admitted to the facility on 1/25/11. reviewed in an effort to ensure all recommended "Resident Progress Notes," dated 1/26/11 psychiatric follow-up has at 8:00 p.m., indicated resident had some been done, and to ensure confusion, was yelling at staff to leave any residents requiring him alone and was non-compliant with referral to PASRR for Level personal alarm. II completion have been referred accordingly. "Resident Progress Notes," dated, 1/26/11 The care plans of all at 1:00 p.m., indicated Resident #C was residents currently receiving easily agitated at staff and yells out and psychotropic medications slaps at staff during care. have been reviewed to ensure the same are Admission care plan for inappropriate addressed. behaviors, dated 1/27/11, indicated The care plans of any resident displays inappropriate behaviors resident who have voiced a as evident by yelling at staff, refusing preference for male versus care, and non-compliant with personal female, or vice versa, alarm. caregivers have been reviewed to ensure the "Resident Progress Notes," dated 1/30/11 same is addressed. at 9:05 p.m., indicated Resident #C takes his nicotine patch off himself. III. Nursing center staff have received in-service "Resident Progress Notes," dated 2/7/11 at education relative to 4:15 p.m., resident removes personal behavior management alarm and hides pieces. process, including but not limited to behavior March nursing assistant care record had assessment, monitoring,

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE and documentation. Social one behavior on the 9th (AM). PM shift Service staff and Licensed had behaviors x2 on 3/1, 2, 3, 4, 5, 6, 7, 8, Nursing staff have received and one on the 9th and two on the 10th. in-service education relative to the care plan process, "Resident Progress Notes," indicated on including but not limited to 4/13/11, resident displayed behaviors inclusion of psychotropic toward CNA per Anna in therapy. medication use, compliance Resident agitated and threw water pitcher with recommended at CNA psychiatric follow-up, and any care preferences Inappropriate behavior care plan, dated voiced by residents. A 1/27/11, had an updated behavior 4/14/11 performance improvement but no new interventions. tool has been developed to monitor compliance with April monthly behavior monitoring behavior management flowsheet had verbal aggression on 4/19. process, as well as PASRR paperwork and required May nursing assistant care record had 3 level II. behaviors on the 2nd. May monthly A performance behavior monitoring flowsheet had improvement tool has been inappropriate gestures on 5/7 and 5/8; developed to monitor verbal aggression on 2nd and 8th. The compliance with addressing monthly behavior summary/psychoactive of psychotropic medications GDR dated June which reviewed May and resident care behaviors had 2 incidents of verbal preferences on care plans. aggression and 1 of inappropriate Executive Director, or gestures. designee, and Social Service staff, or designee, "Resident Progress Notes," dated 6/2/11 at shall be responsible for 6:30 p.m., indicated resident observed completion of these PI tools shoving a glass of milk towards a resident daily, on scheduled days of at his table because resident was tapping work, for 30 days. Any identified concerns will be his cup at the table. promptly addressed with

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			LDING	nstruction 00	(X3) DATE COMPL 11/10/2	ETED		
			B. WIIV		DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8	6006 BRANDY CHASE COVE					
KINDRE	D TRANSITIONAL (CARE AND REHAB-FORT WAYN	E	FORT V	VAYNE, IN46815			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
TAG		*		TAG	responsible individual(s	١	DATE	
	"Resident Progress Notes," dated 6/2/11 at 7:30 p.m., resident witnessed walking past				responsible individual(s).			
		sefully kicking peer.			IV. Social Service staff	will		
					review findings weekly a	and		
	A new care plan	listed resident kicking			report to PI committee			
	another resident	6/6/11. Talked about 15			monthly for 6 months to			
	minute checks.				determine need for			
					continued monitoring thereafter.			
		nitoring Tool," dated			נווכו כמונכו.			
	-	the resident threw a			Completion Date:			
		and that the resident was			12.10.11			
	put on 15 minute	e checks.						
	A "Resident Tra	nsfer Form," dated						
		ed Resident #C was being						
	•	e psychiatric unit at a						
	local hospital du	e to behavioral						
	disturbance.							
	Progress notes fr	om local hospital, dated						
	6/15/11, indicate	ed resident "remains						
		es it clear though that he						
	1 *	npany to femalekeeps to						
		inues to isolate with his						
	_	y remaining in his						
	room"							
	An "External Tra	ansfer Report," dated						
	6/17/11 from a local hospital, indicated Resident #C had been hospitalized from 6/10/11 through 6/17/11 and was being							
	transferred back to the facility. The report							
	indicated the res	ident was confused at						
	times and was to	follow up with psych						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155249	B. WIN	G		11/10/2	011
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	O TO ANIQITION A	CARE AND RELIAD FORT WAYA	_		RANDY CHASE COVE		
KINDREL	J TRANSITIONAL	CARE AND REHAB-FORT WAYN	lE	FORTV	VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	care in 4-6 week	.S.					
	II.a.ital diaabaa						
	•	ge notes indicated the					
		arning to the facility with					
		abilify (antipsychotic)					
	3mg every night	at oculinic.					
	June nurging ago	istant care records for					
	_	viors x 2 on 6/1 and only 1					
		3, 4, 5, 6, 7, 8, 9, 10, 11,					
	20. The June m						
	monitoring flow						
	aggression on th						
		stures on 6/5 and					
		s on 6/2. The July					
		•					
	_	or summary/psychoactive					
	GDR review list	ed no behaviors for June.					
	"Dagidant Progr	ess Notes," dated 7/9/11,					
	_	nt confused and yelling at					
	staff all shift.	it confused and yening at					
	san an siint.						
	 An "Intra-facilit	v Transfer " dated					
	l '						
	· ·						
		-					
	=	-					
	"Resident Progre	ess Notes," dated 7/18/11					
	_						
	"Resident Progre	ess Notes," dated 7/24/11					
	7/12/11, indicate moved from Roo documented] to documented] for "Resident Prograt 9:30 a.m., roo turning off the a the resident had	y Transfer," dated ed Resident #C was om [room number Room [room number bed management. ess Notes," dated 7/18/11 mmate reported writer ir in their room and what said to the CNA. ess Notes," dated 7/24/11					

000153

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	NSTRUCTION 00		E SURVEY PLETED 2011	
		133243	B. WIN		PPPPGG GYMY GM MP GYP GOV		2011
NAME OF F	PROVIDER OR SUPPLIE	R		1	DDRESS, CITY, STATE, ZIP COI RANDY CHASE COVE)E	
KINDREI	D TRANSITIONAL	CARE AND REHAB-FORT WAYI	NE		VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPENCIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	· ·	A instructed resident to es and resident stated "Go					
	yourself."	es and resident stated. Go					
	yoursen.						
	"Resident Progr	ess Notes," dated 7/25/11					
	_	esident became upset in					
		ng because a resident					
		his food with her w/c					
	_	threw silverware on the					
	ground and left						
	July nursing ass	istant care record had no					
	behaviors marke	ed. The July monthly					
	behavior monito	oring flowsheet listed					
	verbal aggressio	n on 7/18 and 7/25.					
		ess Notes," 7:30 a.m.,					
	_	CNA for asking him to					
	change out of di	rty clothes.					
	"Determining C	ause of Disruptive					
	1	d 8/18/11, indicated					
	· ·	essive behavior. It					
	1	sident was upset with the					
		o was temporarily moving					
	_	rom room to lounge while					
		up/replaced. The report					
		ent #C hit the housekeeper					
		sible trigger "did not					
		that his things were being					
	1	ved, thought things were					
	being taken" See nurse's notes for						
	further details.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155249	B. WIN	IG		11/10/2	011
NAME OF I	PROVIDER OR SUPPLIEI	3	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
					RANDY CHASE COVE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYN	٧E	FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		assistant care records have					
		Ionthly behavior					
	_	sheet for August had one					
	inappropriate ge	sture on the 30th, and					
	verbal aggressio	n on the 3rd, 6th, 9th,					
	12th.						
	Consultant phari	macist's medication					
	regimen review,	dated 8/28/-8/30/11,					
	indicated labs w	ere missing in the chart.					
		note indicated the resident					
	had refused and	the orders were canceled.					
	A care plan for r	risk for adverse effects					
	•	psychotropic medication					
		0/8/11 however abilify					
	was started in Ju	•					
	was started in sa	iiio.					
	A care plan for s	self care deficit (ADL),					
	-	d not list the resident					
		did not list that resident					
	-	g showers and changing					
	clothes or other						
	cionies of other	uchaviuis.					
	Contombor numi	na aggistant agra record					
	_	ng assistant care record -					
		hight shift 9/1. There was					
	no September m	_					
	monitoring flow	sneet.					
	UD 11 ID	NT / H 1 / 140/0/44					
	_	ess Notes," dated 10/3/11					
	at 4:50 p.m. Incident when resident						
		oy. Doctor notified at					
	_	rder received to send					
	resident to St. Jo	e for evaluation and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE COMPL 11/10/2	ETED	
NAME OF A	AN OLYMPIER OR GURDY HER		B. WIIV		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	(6006 BF	RANDY CHASE COVE		
KINDREI	O TRANSITIONAL (CARE AND REHAB-FORT WAYN	E	FORT W	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	treatment.	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCE!)		DATE
	treatment.						
	Δ "Resident Tra	nsfer Form," dated					
		ed Resident #C was					
	•	ocal acute hospital					
		. Diagnoses included:					
	schizoid persona	_					
	_	accident (stroke), anemia					
	and congestive h	eart failure. The reason					
	for transfer listed	d increased agitation with					
	the resident push	ning a 3 y/o child down.					
	The additional p	ertinent information					
	indicated the res	ident pushed a visitor's 3					
	-	ho was on the scale. The					
		child to "get his little					
		ote further indicated the					
	_	ulsive behavior, some					
	problems with te	emper and anger at times.					
	October nursing	assistant care records had					
		rked. October monthly					
	behavior monito	ring flowsheet had one					
		ical aggression and anger					
	with others on 10	0/3.					
	Interdisciplinary	Discharge Summary,					
	dated 10/3/11, in	dicated: discharged to					
	local hospital for	r abusive behaviors.					
	_	ed to be alone, listen to					
	his Walkman or	watching television.					
	The current police	cy and procedure for					
	_	iting Challenging					
	Behaviors," date	d 6/30/06 was provided					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155249	A. BU. B. WII				11/10/2	011
			b. WII		DDRESS, CITY, STA	ATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			RANDY CHASE			
		CARE AND REHAB-FORT WA	AYNE		VAYNE, IN4681			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	ΤE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFI	ICIENCI)		DATE
	*	of Nursing on 11/10/11 at						
	_	policy listed the						
	_	resident exhibiting						
		om is intervened with						
	measures that re	educe and/or eliminate						
	_	es while protecting the						
	resident and/or of	others from harmrecord						
	the behavior(s)	exhibited, interventions						
	tried but unsucc	essful, and/or successful						
	interventions use	ed on behavior monitoring						
	log or similar tra	acking deviceupdate the						
	resident's care p	lan, as						
		unicate resident behavior						
	symptoms to app							
		luate resident condition						
	_	t least 72-hours or more						
	frequently as de							
		teamdocument						
		ents of resident's behavior						
	1 -	dical recorddetails of the						
	eventstaff mor							
		ument behaviors and						
		behavior monitoring log						
	or similar tracki	ing device						
	The Health Faci	ility Administrator,						
		sing (DON) and Social						
		#3 were interviewed on						
		20 p.m. During the						
		Iditional care plans were						
		listed employees. The						
	1 ^	the resident had a male						
		time before he changed						
		t wasn't care planned.						
FORM CMC 2			4B0)(;;	E 377 I	D: 000450	IC	5	
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event ID:	4R9X11	Facility I	D: 000153	If continuation sh	ieet Pa	ge 35 of 44

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155249	B. WING		11/10/2011
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
KINDDE	O TO ANOITION AL	OADE AND DELLAR FORT WAYA		RANDY CHASE COVE	
KINDREL		CARE AND REHAB-FORT WAYN	E FORT	WAYNE, IN46815	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	This Endoral too	ralates to Complaint			
		relates to Complaint			
	IN00099184 and	a IN00099274.			
	3.1-35(a)				
	3.1-35(b)(1)				
	3.1-35(b)(2)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	LDDIC	00	COMPL	ETED
		155249	A. BUII			11/10/2	011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINIDDEL	TDANSITIONAL (CARE AND REHAB-FORT WAYN	-		RANDY CHASE COVE VAYNE, IN46815		
1							
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
F0285	,	ordinate assessments with					
SS=D		screening and resident					
	. •	nder Medicaid in part 483, naximum extent practicable					
	•	e testing and effort.					
	to avoid dupileativ	c testing and enort.					
	A nursing facility n	nust not admit, on or after					
		any new residents with:					
		as defined in paragraph (m)					
	(2)(i) of this sectio	n, unless the State mental					
	health authority ha	as determined, based on an					
		ical and mental evaluation					
		erson or entity other than the					
		h authority, prior to					
	admission;						
		se of the physical and					
		of the individual, the street the level of services					
	provided by a nurs						
		ual requires such level of					
		the individual requires					
		es for mental retardation.					
	•	ation, as defined in					
	paragraph (m)(2)(ii) of this section, unless the					
	State mental retar	dation or developmental					
	disability authority	has determined prior to					
	admission						
		se of the physical and					
		of the individual, the					
	•	the level of services					
	provided by a nurs	sing facility; and lual requires such level of					
		the individual requires					
		es for mental retardation.					
	For purposes of th	is section:					
		s considered to have					
	"mental illness" if	the individual has a serious					
	mental illness defined at §483.102(b)(1).						
		is considered to be					
		" if the individual is mentally					
	retarded as define	d in §483.102(b)(3) or is a					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE COMPL		
		155249	A. BUII B. WIN			11/10/2	011
NAME OF I	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE		
KINDRE	D TRANSITIONAL (CARE AND REHAB-FORT WAYNE	Ξ		WAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ted condition as described					
		review and interview, the	F0	285			12/10/2011
	facility failed to	notify Pre-admission			F 285		
	_	dmission Screening					
		(PASRR) of a change in			I. Resident #C no longe	er	
		ew diagnosis for 1 of 3			resides in the nursing		
		ed for PASRR services.			center, therefore, no fur corrective action could l		
	[Resident #C]				taken for this resident.	be	
	Fin din en in els de				taken for this resident.		
	Findings include) <u>.</u>			II. All residents with		
	Resident #C's re	cord was reviewed on			behaviors have the		
		a.m. The record			potential to be affected,		
		ent #C's diagnoses			therefore, this plan of		
		ere not limited to,			correction applies to all	of	
	· ·	(hip), cerebrovascular			those residents. The		
		, chronic obstructive			medical records of these	е	
	` ′	se, legal blindness, and			residents have been		
	schizoid persona	, •			reviewed to determine in behaviors have been	f	
					appropriately assessed		
	A "Pre-Admission				monitored, and		
	1	el 1, dated 1/24/11,			documented with any		
		nt #C did not have any			identified concerns		
	behaviors or				corrected. All resident		
		tianxiety/antidepressant			records have been		
		was going to LTC for			reviewed in an effort to		
	short term rehab				ensure all recommende		
	History and Dhy	sical from a local			psychiatric follow-up ha		
		/10/11, indicated			been done, and to ensu	re	
		n extended care facility,			any residents requiring	1	
		came increasingly agitated			referral to PASRR for Lo		
	_	this patient has been an			Il completion have beer		
	and combative	uns pauent nas occii an			referred accordingly. Th	ਦ 	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 11/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE extended care facility resident since he care plans of all residents currently receiving had a fractured hip in February 2011...." psychotropic medications have been reviewed to A "Resident Transfer Form," dated ensure the same are 6/10/11, indicated Resident #C was being addressed. transferred to the psychiatric unit at a The care plans of any local hospital due to behavioral resident who have voiced a disturbance. preference for male versus female, or vice versa, Progress notes from local hospital, dated caregivers have been 6/15/11, indicated resident "remains reviewed to ensure the schizoidal...makes it clear though that he same is addressed. prefers male company to female...keeps to himself and continues to isolate with his III. Nursing center staff headphones or by remaining in his have received in-service room...." education relative to behavior management An "External Transfer Report," dated process, including but not 6/17/11 from a local hospital, indicated limited to behavior Resident #C had been hospitalized from assessment, monitoring, 6/10/11 through 6/17/11 and was being and documentation. transferred back to the facility. The report Social Service staff, indicated the resident was confused at Business Office Manager, times and was to follow up with psych and Admissions care in 4-6 weeks. Coordinator have been in-serviced on PASRR A "Nursing Assessment/Full," dated process and requirements, 6/17/11, indicated Resident #C was including but not limited to admitted to the facility on 6/17/11 and the need for a Level II indicated a new diagnosis of schizoid referral in the event of a disorder. The form did not list that the behavioral condition resident was on the antipsychotic change. medication abilify. It again listed the Social Service staff and resident as a non-smoker, that the resident Licensed Nursing staff have

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155249	B. WING	}		11/10/2	011
KINDREI		CARE AND REHAB-FORT WAYNE		6006 BF	DDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE /AYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	was occasionally mental retardation A "Doctor's Programmental form of the state out to a local psy increased comba mental health his resident was on a medication) for substantial Social Services # 11/10/11 at 10:50 interview, Social PASRR was not reassessment (Lease of the state of the sta	gress Notes," dated de Resident #C was sent vehiatric unit due to tiveness, agitation with story. Indicated the Ability (antipsychotic schizoid disorder. #2 was interviewed on 0 a.m. During the 1 Services #2 indicated notified of the need for a evel 2).			received in-service education relative to the care plan process, inclu- but not limited to inclusio of psychotropic medicat use, compliance with recommended psychiatr follow-up, and any care preferences voiced by residents. A performance improvement tool has be developed to monitor compliance with behavio management process, a well as PASRR paperwo and required level II. A performance improvement tool has be developed to monitor compliance with address of psychotropic medicat and resident care preferences on care pla Executive Director, or designee, and Social Service staff, or designe shall be responsible for completion of these PI to daily, on scheduled days work, for 30 days. Any identified concerns will to promptly addressed with responsible individual(s)	ding on ion ion ion ion ion ion ion ion ion	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249			(X2) MU A. BUIL B. WINC		OO	(X3) DATE S COMPL 11/10/20	ETED
	ROVIDER OR SUPPLIER	CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN46815				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0406 SS=D	but not limited to, papeech-language papeech-language papeech-language papeech-language papeech and ment services for mental retardation, are recomprehensive plaprovide the require required services faccordance with § a provider of special services. Based on record facility failed to a appointment was as requested after	pathology, occupational al health rehabilitative al illness and mental quired in the resident's an of care, the facility must ed services; or obtain the from an outside resource (in 483.75(h) of this part) from falized rehabilitative review and interview, the ensure a psychiatric scheduled and attended ar a local psychiatric	F04	406	IV. Social Service staff or review findings weekly a report to PI committee monthly for 6 months to determine need for continued monitoring thereafter. Completion Date: 12.10.11 F 406 I. Resident #C no longeresides in the nursing center, therefore, no furting the review of the residence of the review of th	nd	12/10/2011
	-	e for 1 of 3 residents ointments. [Resident			corrective action could b taken for this resident.		
	Findings include	:			II. All residents with behaviors have the		
	Resident #C's rec 11/9/11 at 10:00 indicated Resident included, but wer	nt #C's diagnoses			potential to be affected, therefore, this plan of correction applies to all of those residents. All resid records have been		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155249		LDING		11/10/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t.		1	RANDY CHASE COVE		
KINDRE	D TRANSITIONAL (CARE AND REHAB-FORT WAYNI	Ξ		VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		(hip), cerebrovascular			reviewed in an effort to	-I	
	` ′	, chronic obstructive			ensure all recommende		
	1 ^	se, legal blindness, and			psychiatric follow-up has		
	schizoid persona	lity.			been done, and to ensu	re	
					any residents requiring		
		sical from a local			referral to PASRR for Le		
	hospital, dated 6				II completion have been		
		n extended care facility,			referred accordingly.		
	who recently bed	came increasingly agitated					
	and combative	this patient has been an			III. Nursing center staff		
	extended care fa	cility resident since he			have received in-service	•	
	had a fractured h	ip in February 2011"			education relative to		
					behavior management		
	A "Resident Tran	nsfer Form," dated			process, including but n	ot	
	6/10/11, indicate	ed Resident #C was being			limited to behavior		
	· ·	e psychiatric unit at a			assessment, monitoring		
	local hospital du				and documentation. Soc	cial	
	disturbance.				Service staff, Business		
					Office Manager, and		
	 An "External Tra	ansfer Report," dated			Admissions Coordinator		
		ocal hospital, indicated			have been in-serviced o	n	
		been hospitalized from			PASRR process and		
		6/17/11 and was being			requirements, including		
		to the facility. The report			not limited to the need for		
		ident was confused at			Level II referral in the ev		
					of a behavioral condition		
		follow up with psych			change. Social Service		
		s. No follow up was			and Licensed Nursing s		
	done.				have received in-service		
		1 . 1			education relative to the		
		s conducted with Social			care plan process, inclu		
		1/10/11 at 12:20 p.m.			but not limited to inclusion		
	_	view, Social Service #2			of psychotropic medicat	ion	
		vas no follow up to a			use, compliance with		
	psychiatric visit	requested upon discharge			recommended psychiatr	ic	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPL 11/10/2	ETED		
		100210	B. WING	_		1 17 10/2	· · ·	
	PROVIDER OR SUPPLIER D TRANSITIONAL (R CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN46815					
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL L SC IDENTIFYING INFORMATION	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION	
TAG	from a local psyd June for Residen	relates to Complaint		TAG	follow-up, and any care preferences voiced by residents. A performance improvement tool has be developed to monitor compliance with behavior management process, a well as PASRR paperword and required level II. A performance improvement tool has be developed to monitor compliance with address of psychotropic medicat and resident care preferences on care plate Executive Director, or designee, and Social Service staff, or designed shall be responsible for completion of these PI to daily, on scheduled days work, for 30 days. Any identified concerns will be promptly addressed with responsible individual(s). IV. Social Service staff review findings weekly a report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.	een or as ork een sing ions ns. ee, ools s of oe n). will and	DATE	

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	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/10/2011
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE	1
		CARE AND REHAB-FORT WAYNE	FORT \	WAYNE, IN46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	1	CY MOST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION DATE